Wisconsin Department of Regulation & Licensing

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MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

PROFESSIONAL COUNSELOR CERTIFICATE OF PROFESSIONAL EDUCATION

APPLICANT: Complete the top portion of this form and forward to your professional school. Request the school to return the completed form directly to the **Professional Counselor Section.**

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ SOCIAL SECURITY # _____
(MONTH) (DAY) (YEAR) Voluntary, for use by school to locate your records

APPLICANT: DO NOT WRITE BELOW THIS LINE

CERTIFYING SCHOOL – Please complete this section.

_____ _____
NAME OF INSTITUTION LOCATION OF INSTITUTION (City/State)

_____ _____
DEGREE AWARDED MAJOR

☐ Please check if CORE or CACREP accredited.

_____ _____
DATE OF DIPLOMA NAME OF THE ACCREDITING BODY AT THE TIME STUDENT RECEIVED DEGREE

I certify that the above information is true

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____

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